AVIDA PT

PHYSICAL THERAPY

AVIDAPT

1391 Dublin Rd, Columbus, OH 43215

614-487-9715 | avidapt.com |

Welcome to Avida PT. The purpose of this letter is to provide you with some helpful information to prepare you for your visits to our facility.

Prior to your evaluation your primary insurance will be verified and if necessary authorization obtained. If you have secondary insurance that also will require verification and authorization. It is suggested that you call the Member Service department at your insurance company and verify what your responsibilities may be regarding co-pays, deductibles, referrals, etc. Please remember that benefits quoted are not a guarantee of payment per your insurance.

Any questions regarding scheduling should be directed to the administrative personnel at 614-487-9715

When you arrive for the evaluation please come to the Front Desk and have with you:

1. Your insurance card.
2. Prescription or referral as necessary or if needed by your insurance company.
3. Copy of Photo ID.
4. Any co-pay, coinsurance or deductible payment as required by your insurance.
5. Current medication list.

After the evaluation has been completed, the therapist will discuss with you a treatment program.

If you have any questions or we can be of any assistance to you please call us at 614-487-9715

We look forward to seeing you.

Appointment Reminder
Consent

Client Full Name: ____________________

Complete this form and sign below to give your permission for Avida PT, Inc to provide automatic appointment reminder service by email or by cell phone text message.

Step One: Select One Option Below

- ☐ Avida PT, Inc may send email messages to confirm my upcoming appointments to: ____________________
- ☐ Avida PT, Inc may send cell phone text messages to confirm my upcoming appointments to : ____________________

I recognize that normal text messaging rates may apply.

Step Two: If you would like text messages instead of email reminders, please indicate your Cell Phone Carrier.

We cannot set your account up to send email text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

- ☐ ALLTel
- ☐ AT&T
- ☐ Boost Mobile
- ☐ Cingular
- ☐ Cricket Wireless
- ☐ Metrocall
- ☐ MetroPCS
- ☐ Nextel
- ☐ Qwest
- ☐ Sprint PCS
- ☐ T Mobile
- ☐ US Cellular
- ☐ Verizon
- ☐ Virgin Mobile

____
Signature of Patient or Guardian

____
Date

ACKNOWLEDGMENT OF RECEIPT

I, ____ acknowledge that I have received the Notice of Privacy Practices issued by Avida PT, Inc

I, ____, authorize Avida PT, Inc to discuss my health information with the following persons:

Name Relationship Contact Information
(ie:if you would like your family doctor to receive information please include them here)

____

____

____

____

____

____

_________________________ ____
Date Signature of Patient/Guardian

PATIENT INTAKE INFORMATION FORM

Name_______________________________ Birth Date___________________

Address:____________________________ City:______________________ State: ________Zip____________

Home Phone:_________________________ Cell Phone: _________________ Work Phone: _______________

Email Address:______________________________ Height: ______________ Weight: ____________________

How did you hear about our clinic? ____
If by internet was it: (circle one) Google Yahoo Yelp Bing Other

Employer/ School: ____ Address: ___________________________

City: _______________________________ State: ________ Zip: __________ Job Title: ____________________

Emergency Contact: ____ Phone: _____________________________

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance Co. Name		Insurance Co. Name	
Policy Holder		Policy Holder	
Relation to patient		Relation to patient	
Policy Holder date of birth		Policy Holder date of birth	
Policy Holder Employer		Policy Holder Employer	
Member ID #		Member ID #	
Group #		Group #	
Date Verified/ Spoke with	/	Date Verified/ Spoke with	/
# of visits allowed/ Used	/	# of visits allowed/ Used	/
Copay or co-insurance		Copay or co-insurance	
Deductible/ Met	/	Deductible/ Met	/
Pre-cert needed Y or N		Pre-cert needed Y or N	
Out of pocket/ Met	/	Out of pocket/ Met	/
Effective Date/ Plan Year	/	Effective Date/ Plan Year	/
Self Pay			
Avida PT rep reviewed details with patient		Avida PT rep reviewed details with patient	

Referring Physician: _________________________ Date of next physician appointment: ____________

What was the date of your injury or onset of symptoms? __________________________

Briefly describe how your problem began: ____

What are your current symptoms/ reason for being here? ____

What makes your symptoms worse: ____

What makes your symptoms better: ____

What are your goals for rehab? ____

Previous Orthopedic injuries: ____

If you have pain, please rate it with "0" being pain free and "10" being worst pain possible:

Pain at least: 0 1 2 3 4 5 6 7 8 9 10

Pain at worst: 0 1 2 3 4 5 6 7 8 9 10

Please list allergies: ______________________________ Are you allergic to latex? Yes No

Please list **all medications** you are currently taking:

Are you currently being treated by another health care professional or a chiropractor? Yes No For:

Current and past medical history, circle all that apply:			
Diabetes	Rheumatoid	Cancer	Epilepsy
Pacemaker	Osteoarthritis	COPD	Seizures
High Blood Pressure	Osteoporosis	Asthma	Anxiety
Heart Trouble	Joint Implants	Chest Pain	Depression
Stroke	Hemophilia	Currently Pregnant	

Current exercise routine, frequency, etc. ____

Do you have any cultural or religious considerations we need to know about before you begin treatment? Yes No

If Yes please explain: ____

Worker's Compensation

Was your injury or illness incurred at work? Yes No Is BWC covering your therapy? Yes No
Did you file a claim with your employer? Yes No Do you have a case manager? Yes No
Case Manager's Name: ______________________________ Phone:__________________________

CONSENT AND RELEASE
I hereby give my consent to Avida PT, Inc. to perform such tasks, evaluations and procedures upon my person as may be directed by my physician. During my appointments Avida PT, Inc. is not responsible for loss or damage to my personal property.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS
I am personally responsible for the payment of all charges incurred through Avida PT, Inc., and hereby assign all benefits from any insurance policies of employee healthcare benefit programs. I authorize and direct such policies or programs to make payments directly to Avida PT, Inc.

MEDICARE PATIENTS
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration of its intermediaries or carriers of any information needed for this or a related medical claim.

AUTHORIZATION FOR RELEASE OF INFORMATION
I authorize Avida PT, Inc. to release medical information to any physician treating me during this visit. I also authorize the release of information to the insurer or its agents processing the claim for payment.

Avida PT, Inc. reserves the right to discharge a patient who frequently cancels or no shows for their appointments.
Avida PT, Inc. takes pride in scheduling 45 minute one-on-one appointments. Because of this, we reserve the right to charge a $25 no-show or cancellation fee if given less than 24 hours notice.

PATIENT/PARENT SIGNATURE:________________________________**DATE:**_______

This registration has been reviewed by attending therapist________(PT Initials)